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ON

SYPHILIS AS AN IMITATOR.

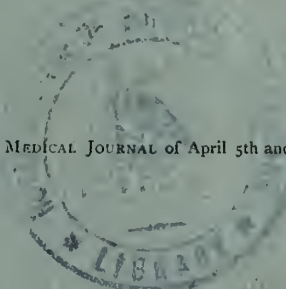
AN ADDRESS DELIVERED BEFORE THE LANCASHIRE AND
CHESHIRE BRANCH OF THE BRITISH MEDICAL
ASSOCIATION.

BY

JONATHAN HUTCHINSON, F.R.C.S.,

SENIOR SURGEON TO THE LONDON HOSPITAL AND TO THE HOSPITAL FOR SKIN-DISEASES,
AND CONSULTING-SURGEON TO MOORFIELDS OPHTHALMIC HOSPITAL.

[Reprinted from the BRITISH MEDICAL JOURNAL of April 5th and 12th, 1879.]



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SYPHILIS AS AN IMITATOR.

MR. PRESIDENT AND GENTLEMEN,—An idea has much occupied my mind, during the last few years, which seems to considerably simplify our creed as regards the nature of the very various forms of disease which are caused by syphilis. It is, that we ought to recognise, in syphilitic forms of inflammation, imitations, with certain differences, of the other and more common types of diseased action which occur without any connection with specific taint. The fact, as a matter of clinical observation, must have been obvious to all for long; and the names which the various types of syphilitic eruption have received recognise it. As a rule, we are content to apply the adjective “syphilitic” to some substantive which designates a well-known form of non-specific skin-disease, “syphilitic psoriasis”, “syphilitic roseola”, and the like.

This recognition of the doctrine which I purpose to propound to-day, in some detail, is so general and so old, that I might, perhaps, almost need to apologise for making it the subject of a special discourse, were it not that I hope to be able to show that it has ramifications which have as yet scarcely received the attention they deserve. To my own mind, I may acknowledge that this general law of imitation or simulation has been of the greatest possible service; and that it has helped me to a clear view of much that was previously obscure. There is no difficulty in explaining why syphilis, in its action upon the solids and fluids of the human body, should be an imitator of old types, and not an originator of new ones, if we admit, as probable, that almost all possible forms of morbid process existed already independently of it. The introduction of the syphilitic virus into the system simply gives a tendency to derangement of cell-nutrition, resulting in local inflammation. All such derangements must be regulated in their development by anatomical conditions and physiological laws. Certain structures exist which will be attacked, and their number and variety is not unlimited. There are in

the skin, for example, certain glands, papillæ, vascular areas, and special appendages; and any of these may be attacked by disease; and the possible variety as to its anatomical location, although great, is still restricted. Syphilis cannot devise for itself any new set of organs, nor can it lay down any new lines along which morbid action, once originated, may spread. It must work in the old grooves, and travel by the existing paths.

A writer, much read in my youth, and now much neglected, remarks, respecting the so-called author of all evil, exactly what I wish to assert of syphilis. "He can mar; but he cannot make; for he is not antagonist deity." In thus denying the original ability of Satan, Mr. Tupper expresses in the language of theological metaphor that which is capable of easy explanation by natural laws. Our vices and our faults are only the results of unbalanced or insane instincts. There is not one of them but has a natural basis in something of itself perfectly laudable. Avarice is only exaggerated prudence; lust springs from virility; envy, covetousness, and the tendency to steal, find their roots in the perception of what is desirable, and the too energetic zest of possession. Given a knowledge of virtue, and we can interpret vice. Now, it appears to be almost exactly so with syphilis amongst diseases. Given a knowledge of other types, and we can foresee on what plans it will work. The number of its simulations is wonderfully great. I will enumerate briefly some of the most remarkable of them.

In connection with what some name the darts diathesis—an unknown peculiarity of health, or of skin, which gives proclivity to skin-affections—we have several very definite and distinct forms of eruption: first, *common psoriasis*, an eruption consisting of increase of epidermal elements in patches, with vascularity and swelling of the derma beneath; next, *lichen-psoriasis*, or *lichen ruber*, consisting of grouped lichen spots, which may merge together and become smooth and polished, but are rarely very scaly; thirdly, *pemphigus*, the eruption consisting of bullæ, which contain clear serum. To these might be added a number of minor modifications less generally known, and which it would be tedious to describe. All these agree in that they occur to healthy persons, prefer young adults, never occur to infants, never get well of themselves, relapse after apparent cure, and are always influenced for good by arsenic and tar. It is clear that they are modifications of the same malady; and although in external appearance very different, yet their essential resemblances (just enumerated) far exceed their apparent differences. We may suspect that their differences depend upon peculiarities in the indi-

viduals who become their subjects, and that their cause is in all the same. Now, it is of extreme interest to note that, in syphilitic secondary rashes, we have all these reproduced, thus proving that one and the same cause may in different persons produce very different results. Syphilitic psoriasis is well known; syphilitic rupia is the representative of non-specific pemphigus; and those familiar with lichen ruber will not unfrequently find in syphilitic eruptions an exact imitation of it. But the varieties of the syphilitic secondary rash are by no means exhausted by its reproduction of the common forms of the dartsous malady; for we have also imitations of the exanthems, and of some much more rare types of eruption. Syphilitic roseola is, so far as the anatomy of the lesion is concerned, measles; certain forms of diffuse erythematous lichen closely resemble scarlatina, and there is a pustular rash exactly like variola. This last imitation by syphilis is so remarkable, and may lead to such serious errors in diagnosis, that I must advert to it in more detail. It has been carefully described by Dr. Liveing.

In the form of syphilitic eruption which looks like small-pox, the rash is scattered symmetrically over face, limbs, and trunk; it may be discrete or confluent, according to its abundance; the pimples are hard and shotty at first; they have depressed centres, they form adherent scabs, and they leave scars. The eruption differs, of course, from true variola in the slowness of its evolution, in its long persistence, and its very slow decline; and it is only in its early stages that mistakes in diagnosis are likely to occur. Even in these, the comparatively small amount of febrile disturbance, and the absence of backache, will usually excite suspicions which may probably be converted into certainties by examination of the patients' genitals, and the discovery of a chancre. One of the most remarkable examples of this eruption came under my notice about twelve years ago. A young gentleman called on me with a conspicuous papular eruption on his face and other parts. "I have just had small-pox", he said; "and Mr. — says that I am cured; but the spots don't go away." He added that Mr. —, a gentleman of large experience, had kept him in bed a fortnight, and had since sent him into the country for a fortnight, and now said that he might return to his desk at a bank; "but", he continued, "the other clerks won't sit near me, and declare that I have small-pox still". He had a chancre, and the eruption was syphilitic. I have seen several cases which had been treated in the small-pox hospital for eruptions which were undoubtedly syphilitic. But I must not mention the mistakes of others, unless I am prepared to be candid about my own. I had many a time

in clinical lecture mentioned the preceding facts, and enlarged upon the importance of distinguishing between the syphilitic simular of small-pox and the reality, when my own turn came. One day in the summer of 1877, I was hastily summoned to see a gentleman at his own house, who had just been landed from a sea-voyage, during the whole of which he had been very ill. He had been carried from the vessel to his house, and put to bed; and I found him covered from head to foot with crusts exactly like those of variola in the third stage. Some had fallen, and, where this had happened, deep scars were left. The eruption had begun to come out on the day that he went on board, and he had been feeling ill a few days before. The stages had been unusually long, but still had not exceeded possible limits. I questioned him as to syphilis, and examined his penis and his throat, but without finding any reason to doubt his denial. In a word, after a careful and sceptical investigation, I thought that the eruption was variola. The sequel proved that it was syphilis; the scabs took months to fall; and, just when he was recovering from the eruption, he had iritis, which I could not doubt was specific. At this stage, three or four months after I had seen him at home in bed, he came to Moorfields Hospital. His face was pitted all over, and I had much difficulty in convincing those who then saw him that he had not really had small-pox. I could not quote an instance more conclusive in support of the assertion that one of the forms of syphilitic eruption is exactly like small-pox in all its stages, and in its resulting scars. Slow progress is the one difference between the two exanthems. The similarity is produced, no doubt, by the fact that syphilis in these cases attacks precisely the same anatomical structures as those in which the variolous pustule is developed. It is scarcely needful to remark that this form of eruption always occurs in the secondary stage.

Syphilitic *roseola* is well known. It is a very common form of rash, usually occurring in the very beginning of the secondary phenomena. We have a mottled congestion of the skin, in ill-defined crescentic patches, exactly like those of measles. As in measles, it is almost wholly an erythema—that is, a dilatation of blood-vessels in patches; and, if the skin be stretched, the vessels may be emptied, and the rash vanishes. Syphilitic *roseola* is less bright in tint and less conspicuous than measles, but in all other respects the eruptions are alike; and no doubt they are produced under the same laws as regards the local vascularisation of the parts. In other words, there exists, no doubt, in the skin a certain arrangement of areas of capillary vessels which, under irritation, permits of temporary paralytic dilatation, with the result of

patches of congestion peculiar as to size and shape. The poisons of syphilis and of measles alike possess the power (in common with certain other causes—copaiba, for instance) of so irritating the vaso-motor nerves as to cause the dilatation of these pre-existing tufts.

Syphilitic *pemphigus*, a bullous eruption, in the first instance exactly like common pemphigus, rapidly changes into what is more usually styled rupia. Under the latter denomination, it is attended by heaped scabs, and by ulcerations at the base, and differs much from any non-syphilitic eruption. It is, however, of the initial lesion that I chiefly speak; for it is to be admitted that all syphilitic imitations are most close in their beginnings, and that they all develop peculiarities after lasting for a time, which much facilitate their differentiation. These peculiarities are mainly a tendency to persist long, a tendency to suppurate and to ulcerate, and, third, a tendency to be serpiginous—that is, to infect the adjacent tissues, and thus to creep over considerable areas.* This latter feature belongs especially to diseases in the tertiary stage, and is seldom seen in the secondary.

The eruption described by Wilson under the name of *lichen planus*, and by Hebra under that of *lichen ruber*, and for which I much prefer that of *lichen-psoriasis*, is a peculiar and interesting one. An adult in good health suddenly becomes the subject of a symmetrical eruption, which consists of dusky lichen spots, arranged in groups which are often linear, and never round, and which tend to coalesce and form patches, which become smooth and polished. It is not syphilitic; it is curable by arsenic and tar, just as psoriasis is, and, like it, it is liable to relapse. Clearly the two are very closely related, differing chiefly, perhaps solely, in the local anatomical lesions. Now, although, as stated, the original type of this malady is certainly non-specific, and requires arsenic and not mercury for its cure; yet a syphilitic imitation of it, in which the resemblance is most close, is very common. I have myself many more opportunities for studying syphilitic lichen ruber than the original malady. I show here an excellent portrait of it, taken from Mr. Wilson's *Atlas*, and to which is affixed the name lichen syphiliticus corymbosus. It was published before lichen ruber was recognised, and is a good proof of the originality and accuracy of Mr. Wilson's observation.

It would be tedious to enumerate all the minor varieties of the eruption which occurs as part of the secondary stage of syphilis, and to

* This curious fact supports the belief that in the secondary stage the poison is free in the blood, and that in the tertiary it is the solid tissues which are altered. Thus in the secondary all parts are equally supplied by the poisoned blood, and individual patches do not creep.

attempt to find their parallels. It may well suffice to say that there are several less frequent forms, both in relation with the dartsy diathesis and the syphilitic state, and that their laws of similarity appear to be just the same as in the definite examples which I have quoted. I will pass on to consider certain affections which occur in the later periods.

A disturbed state of nutrition of the skin in the palms and soles, resulting in breaking up of patches of epidermis, the formation of fissures, etc., is a common condition some years after syphilis, and is usually called *psoriasis palmaris*. It has nothing to do with true psoriasis. So frequent is it in association with a taint of syphilis, that I believe many think that it is in itself conclusive evidence of it. Such, I am convinced, is a great mistake. So-called psoriasis palmaris is often a senile change, and is much helped by local irritation, the use of tools, etc., and it may occur in connection with nerve-disturbance, as for instance, in locomotor ataxy; not, perhaps, in more than half its examples is it of syphilitic origin. The fact that there exists such a widely spread creed as to its being always specific, is conclusive in support of my proposition, that its syphilitic imitation is exceedingly close to the original. Only by very minor features, appreciable only to the most experienced, can the differential diagnosis be made. In many instances, it cannot be made at all, and nothing but the patient's history can help us in the conjecture as to its real cause. Often, no doubt, syphilis predisposes, and other influences help.

Lupus is one of the maladies which syphilis often simulates. Common lupus has, I must hold, no connection whatever with syphilitic taint, either inherited or acquired, but is certainly an appanage of the scrofulous dyscrasia. Overwhelming evidence on this point, and in confutation of those who think it always due to syphilis, might easily be given, but would require more time than is at my disposal, and I must ask to be allowed to assume the fact as proved. Now, the lupus process consists essentially in the growth of cell-structures (possibly adenoid) in the true skin, which destroy the tissues, and, when they retrograde, leave a scar. It is a necessary part of lupus that it should spread serpigiously. Lupus presents us with many varieties; sometimes it ulcerates easily, and sometimes scarcely at all; often it occurs in a single patch, and now and then it is multiple. Now, syphilis mimics it in all its varieties. There is a rare form of eruption usually seen at the end of the secondary stage, in which multiple patches appear in various places on both sides, but rarely symmetrically. These patches look, at first sight, like psoriasis, but, on closer inspection, it

is observed that they spread at their edges, and that they leave scars. They are in reality lupus, and have their prototype in the form of lupus illustrated in this portrait, in which it occurred in a scrofulous child as a multiple eruption. The common horse-shoe ulcer of syphilis is of the lupus type, being attended by new growth, spreading serpigginously and leaving a scar. It is usually tertiary. There is yet another form in which the resemblance is to ulcerating lupus. The nose is the part usually attacked, and it destroys a large part of the organ very rapidly. In bygone years, I have known it diagnosed as escharotic lupus, a term which denotes its rapidity of spreading. In it, the ulceration is at times phagedænic. I show some photographs illustrating this malady. It occurs both in the acquired and inherited disease, but is most common in the latter. It is most important to distinguish this imitation from true lupus, for it may be cured at once by the proper measures, and if neglected, rapidly effects great destruction. It may be distinguished from common lupus, alike by its rapidity, and by the fact that, after it is cured, the scar soon assumes a perfectly healthy state, and that there is no tendency to relapse.

I have seen some rare forms of serpiginous non-ulcerating syphilitic lupus, in which, even with the aid of the history, I have never been able to feel sure of the diagnosis until helped by the results of treatment. But such close counterfeits as these are rare. Let me insist that, in all these varieties of simulated lupus, a correct diagnosis is most important, for there is the greatest possible difference in the results of treatment.

Before leaving this part of my subject, let me ask attention to the fact that syphilis can simulate such peculiar conditions as those presented by Jacobs' ulcer or *rodent cancer*. This ulcer occurs almost solely in the upper parts of the face, and is known by its hard sinuous edge, which is usually free from warty growths, and presents a smooth, even roll of induration. It may heal in the centre, or may be attended by a tolerably clean excavated ulcer. The simulation of these conditions by syphilis is rare, but sometimes very close. I am tolerably well experienced in the diagnosis of rodent ulcer, having seen hundreds of cases; but I may admit that I have two or three times seen hard-edged syphilitic sores which so much resembled it, that, for a time, I was in doubt as to the diagnosis. Here is the portrait of one such, in which I was obliged to write to the surgeon who had known the antecedents of the patient before I could feel sure. The ulcer healed quickly under specific treatment. This simulation of rodent ulcer occurs, I think, only

on the parts on which rodent ulcer is common, and in patients past middle age. I have even seen a few cases in which the realities of rodent ulcer and of syphilis seemed to be mixed.

We will pass now from the skin to the *eye*, and use that as a bridge of connection, from which to enter upon a brief notice of syphilitic counterparts in connection with the nervous system. That syphilitic iritis is so like other forms of iritis that, excepting by its history and concomitants, it is, in nine cases out of ten, indistinguishable, is a point too well known to need insistence. Only in a small minority of cases do the tubercles, which, when present, are so valuable for diagnosis, show themselves. Interstitial keratitis, syphilitic in nineteen cases out of twenty, and almost always so when both-sided, may, in rare instances, find its type in the results of other causes; and the same is the fact respecting punctate keratitis, and some of the more peculiar forms of keratoiritis. But the more noteworthy simulations occur in respect to choroiditis disseminata and retinitis pigmentosa. I show you, first, some drawings illustrating the non-syphilitic forms, and ask you to compare them with others of the latter class. In the two, the process is essentially similar, as closely so as we have just seen to be the case in the instance of lupus-disease of the skin. Patches of choroidal tissue are atrophied at the seat of deposit, which undergoes absorption and leaves areas of denudation. In both, the process is very liable to relapse and to spread. The syphilitic form is by far the more common, and this fact may often help the diagnosis. The imitation of retinitis pigmentosa by syphilis occurs almost solely in the inherited form of the latter disease, and the diagnosis may usually be made by observing that it is not symmetrical, but that one eye suffers much more than the other. When this malady is definitely non-symmetrical, syphilis should be suspected. Some interesting facts, illustrating the closeness of this simulation, have been published by Dr. Fitzgerald of Dublin. In retinitis pigmentosa, whether syphilitic or otherwise, we have an example of slow changes, which steadily advance during many years, disorganise the percipient structures, and are attended by widely-diffused pigment accumulations. It is rather of the nature of a progressive degeneration than of inflammation. The non-specific form is markedly hereditary, and is often in apparent connection with consanguineous marriages. That such a peculiar malady should find a close simulation as a consequence of inherited syphilis, is a very singular and instructive fact. The knowledge that such is the case helps, as I think, to interpret what occurs sometimes as regards the cranial contents. A certain proportion of the sub-

jects of inherited syphilis become slowly almost idiotic, and, without showing positive paralysis, show evidences of some progressive degenerative change in the grey matter of the brain. These patients sometimes find their way into lunatic asylums. In the absence as yet of definite information as to pathological anatomy, may we not plausibly suspect that the changes are allied to those which attend retinitis pigmentosa?

The epilepsy which is such a frequent occurrence as a result of syphilis, both acquired and inherited, probably depends in different cases upon somewhat different local lesions. Sometimes there are other special symptoms which disclose the real nature of the case, but often there is nothing but the patient's history to help to a diagnosis, and to reveal the fact that a cure may be expected from the iodide of potassium.

It will be evident that, in most of what I have said, I have been speaking, not of mere resemblances, but of imitations brought about on plan. But there are certain events in syphilis to which the term resemblance would be more appropriate. Such is the "syphilitic fit", or attack of apoplexy. This by no means unfrequent occurrence supplies often a very close resemblance to an ordinary senile "stroke". There is a short period of confusion, then insensibility, and then paralysis—it may be, hemiplegia. Sometimes several fits, at shorter or longer intervals, occur. These are to be distinguished, however, from what they resemble, in that they are not caused by similar local changes. There is not rupture of blood-vessel and hæmorrhage, but plugging of a vessel and arrest of circulation. They are more nearly parallel to the rare cases of apoplexy from embolism; but from these, again, they differ in that there is local disease of the vessel, which finally becomes thrombosed, not a sudden impaction of a floating plug; and hence certain minor differences in the development of the fit, which, however, I must not now stop to mention.

Under the term Locomotor Ataxy, we recognise a condition of liability to nervous disorder, one of the most conspicuous symptoms of which is a failure of the power of muscular co-ordination in the lower extremities. It is clear that this symptom is only one part of the malady, for the patient is liable to other and quite distinct forms of paresis. He may become blind, may have ptosis or ocular paralysis, and is liable to severe attacks of disturbance of the abdominal organs. The pathology of the malady is to a certain extent made out, and to some extent is yet obscure. It seems clear that low forms of chronic

inflammation, leading to permanent degenerative changes in the posterior columns of the cord, occur; and that these processes, once initiated, tend to spread in certain definite paths. It seems clear that the vasomotor system is often much involved. We do not, however, yet fully understand the bond of connection between the different groups of symptoms; nor do we know the special causes by which they are produced. It seems probable that a variety of causes may in turn or together take shares in causing this curious and very common malady. Now, one of the most remarkable facts in the history of syphilitic simulation is, that all the phenomena of locomotor ataxy may be, and often are, closely imitated. So close is this imitation, that it becomes one of the most difficult tasks in diagnosis with which I am acquainted to distinguish between them. Case after case comes under my observation with the suggestion that the patient is suffering from a syphilitic taint, and I find that all the symptoms range themselves under the head of ataxy. The small and sluggish pupils, the feeble bladder, torpid bowels, the amaurosis, the ptosis and failure of ocular muscles, the stabbing pains, the defective sensation in the feet and diminished coordinative power, the whole group of symptoms, not omitting the abdominal crises, all are there, and yet all are remediable to some extent, if not wholly, by specific treatment. Excepting in the facts as to history, and in the effect of specifics, there is little or nothing upon which to base a differential diagnosis. Whatever may be the parts attacked in non-specific locomotor ataxy, and whatever is the tendency as regards local spreading, it is clear that syphilitic disease may affect the same parts, may spread in the same directions, and may produce precisely similar results. If the question be put, Is there really any non-specific type-form of locomotor ataxy? is it not rather probable that the name is given solely to the results of serpiginous syphilitic changes in the nervous centres? we must, I feel sure, answer it definitely in the negative. It is probable—nay, it is certain—that the disease may begin independently of syphilis; and, notwithstanding the frequency of the latter malady, probably not more than half of those who become the subjects of ataxy have ever had it. It is certain, then, I repeat, that we have side by side two maladies almost exactly alike, one specific and the other not so. It may be asked further whether, in the cases in which ataxy happens in syphilitic persons, it is not yet probable that the ordinary causes are its real producers, and the syphilis merely an accidental concomitant. To this, again, a decided negative answer must be given as regards, at any rate, a considerable proportion

of cases. They are really syphilitic, and are curable only on that hypothesis. On this point, valuable evidence has been produced by M. Fournier of Paris, who has published several remarkable cures by the iodide of potassium, and who urges that, whenever the patient has had syphilis, this drug should be carefully pushed.

In support of the belief that there is such a thing as a slow serpiginous form of inflammation which spreads insidiously amongst the nuclei of special nerves and in certain tracts of the spinal cord, I get most valuable evidence from the cases which I produced in a paper read a fortnight ago before the Royal Medical and Chirurgical Society. The subject of this paper was a condition which may suitably be known as ophthalmoplegia externa, and of which the chief symptom is double-sided partial paralysis of all the ocular muscles. In the most marked cases, both eyelids droop and the eyeballs are almost motionless in the orbits. This affection (previously described by Gräfe) is due, not to disease of nerve-trunks, but of the nerve-nuclei, as made probable by its symmetry; it is progressive, as are certain forms of locomotor ataxy; and it may involve the optic centres and pass down the spinal cord. I cited, in the paper referred to, eighteen cases, and in about two-thirds of them there could be no reasonable doubt that it was due to syphilis. In the syphilitic cases, it is susceptible of arrest by the iodide, and without that remedy the disease is probably usually aggressive and in the end fatal. In many cases, it is mixed up with the symptoms of locomotor ataxy. Whether we prefer to say that it is a symptom of ataxy, or ataxy a symptom of it, does not matter in the least; the important fact is, that both result from a creeping process of disease leading slowly to degenerative changes in the spinal cord and mesocephalon, and having as their consequence various forms of muscular paralysis.

In near connection with this subject, I may refer to a group of symptoms which I described last year before the Royal Medical and Chirurgical Society, and which I believe to indicate disorganisation of the lenticular ganglion. They are: absolute paralysis of the iris, both as regards dilatation and contraction of the pupil, and paralysis of the ciliary muscle. The patient cannot read without strong spectacles, and his pupil does not act in the least. If these conditions be present without other forms of muscular paralysis, they are, I hold, to be explained only on the hypothesis of disease in this ganglion. Now, some of the cases occur in connection with syphilis, and are caused by it; and others have apparently no such association. In some cases, this

ophthalmoplegia interna is probably an early symptom of progressive disease which ends in locomotor ataxy.

A few general remarks may be here introduced as to the features in which syphilitic doubles differ from their prototypes. I have admitted fully respecting several special forms that not unfrequently the similarity is such that diagnosis is possible only by aid of the history and concomitants. This, however, is very exceptional, and, as a rule, minor features of difference are there, and may be made out by careful observation. It may be remarked, in the first place, that the syphilitic forms are seldom quite regular in their course; they are often more rapid in development than their parallels, and often we see mixed up the symptoms of several different forms of disease at the same time. Thus, we may find progressive muscular paralysis with the special symptoms of locomotor ataxy, and what should have been a pure retinitis pigmentosa may be complicated by disseminate choroiditis. In syphilis, the proclivity of all tissues to suffer favours these irregularities of development. The polymorphism of the secondary eruption of syphilis has long been well recognised. Next it may be asserted that a serpiginous tendency or habit is almost constantly more marked in syphilitic inflammations than in others. This is seen alike in the skin and in the connective tissue of the nerve-centres. If the disease be due to syphilis, it will, unless arrested by treatment, tend to spread faster and further than other forms. In the case of external parts, too, the liability to ulcerate, to suppurate, and to become phagedænic must be noted as special features of syphilitic inflammation, and to these we may add the liability to produce scars and to leave pigment-stains. Whenever the evolution of a disease is irregular, and the use of definite nomenclature thus rendered difficult, we may suspect that the malady is syphilitic.

It is time, Mr. President, that I should bring these remarks to a close. In doing so, I can only express the hope that they may have been at any rate suggestive. I have not aimed at proving anything, but have rather endeavoured to give hints as to the way in which I think we ought to work. If the conception of the state of the body left after an attack of syphilis, which I have tried to present to you, be the correct one, it amounts, I think, pretty nearly to this: that every specialised structure, every tissue, every individual cell, is left with increased and peculiar liabilities to disease. No one can tell where the morbid action will show itself, and we must expect it everywhere. Its special locality and form are probably determined by previously existing proclivities. The symptoms produced and the name which will be given to the disorder

will have relation to the structure and function of the organ or tissue which is attacked. Syphilitic maladies must be expected to be as multifarious as are the organs and specialised parts of organs in the body. The lenticular ganglion of the eye has been shown to be liable to disorganisation, and we know more or less definitely what symptoms would follow its destruction. But if this ganglion, why not the others in connection with the cranial nerves? why not those of the abdomen? why not the little ganglion impar itself, which, though so retiring in its solitude, and so unknown as to its special function, must still have its use, and whose loss, could we rightly recognise it, is no doubt felt in some degree? So of all the tissues in the body. It has well been remarked that the author of the proverb *ex pede Herculem* must have been a stupid fellow, for that he ought to have found a toe, or even a toe-nail, quite sufficient from which to evolve the Hero. So of our subject, it may be asserted that the proposition being granted that syphilis gives permanent proclivity to disease in all tissues, a good anatomist and physiologist might write the history of all its very various forms of malady without any clinical experience whatever. We have, however, in part accumulated such experience; we have seen Hercules' foot, and much more; and the task of inference as to the rest becomes so much the easier. I feel confident that the work before us—the discovery and accurate description of a large number of disorders which are of syphilitic origin—will be much helped if we take as our clue in it the general proposition that syphilis is an imitator. It is possible even that some assistance may be gained by work in the opposite direction; and that in some instances, having discovered first the syphilitic type of a special malady, we may find out by investigation the prototype hitherto overlooked.

I must correct what I have just said a little. A knowledge of anatomy and physiology alone would barely suffice to enable its possessor to foresee all that happens in syphilis. There must be some experience also in general pathology as well. Syphilis may claim position as a detector as well as a most skilful simulator. Under its influence, the hitherto latent proclivities of the individual are revealed. When epilepsy occurs from syphilis, it happens probably to a man predisposed to epilepsy; and the same of locomotor ataxy, and the like. The reason why one man in the secondary stage of syphilis shows a scaly eruption, and another a bullous one, is no doubt that peculiarities existed in the individuals which gave a tendency to one or the other form of morbid action. Syphilis in its actions upon the cell-elements of the body

deranges their vital stability and unbalances their forces. It may be said to put a light to a train. The precise character of the explosion will depend upon the quality of the powder and the nature of the surrounding materials,

